Independent Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

Case Number:

Date of Notice: 02/04/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Right shoulders scope SAD biceps tenodesis possible RCR

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

The patient is a with shoulder pain. On 05/16/14, MRI of right shoulder revealed tenderness tendinosis of the distal rotator cuff tendons with partial articular sided fraying/non-fluid filled rotator cuff tear at the supraspinatus distal insertion. There was mild degenerative changes at acromioclavicular joint and mild subacromial fat effacement and bursitis. On 07/10/14, the patient returned to clinic with little improvement with epidural steroid injection. On exam of right shoulder he had 165 degrees of forward flexion that pain was noted going above 90 degrees. He had scapular winging that was mild. He had diminished internal rotation. He had strongly positive Neer and Hawkins test and full 4/5 strength to the rotator cuff limited primarily by pain. There was no capsular instability. Had a positive O'Brien test.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 11/21/14, a notification of adverse determination for right shoulder arthroscopy, subacromial decompression, biceps tenodesis with possible rotator cuff repair noted there was no clinical documentation of fraying or degeneration of superior labrum or type II or IV lesion to warrant biceps tenodesis. Therefore the request was non-certified. On 12/29/14, notification of reconsideration determination noted prior to biceps tenodesis there should be clinical documentation of at least three months conservative care and history and physical examination and imaging studies should indicate pathology. There was no physical examination provided for review and no mention of attempt at any conservative treatment therefore the request was non-certified.

Clinical documentation submitted for review document conservative care in the form of physical therapy at Concentra medical center. Progress notes also indicate the patient had little benefit with steroid injection to right shoulder. For a decompression, there should be clinical documentation of conservative care recommended three to six months, three months is adequate if treatment is continuous. There should also be pain with active arc motion of 90-130 degrees, pain at night, and temporary pain relief

with anesthetic injection. X-rays should show positive evidence of impingement. For biceps tenodesis, guidelines indicate there should be clinical documentation of three months of conservative treatment and type two or four lesion. Guidelines indicate type I and III lesions do not need any treatment or are debrided. There should be definite diagnosis of SLAP lesion strike that there should be history and physical examinations and imaging indicating pathology. The MRI reveals tendinosis of the distal rotator cuff tendons with partial articular sided fraying non-fluid filled tough cuff tear of the supraspinatus distal insertion. There is mild degenerative changes at the acromioclavicular joint, there is no labral tear noted. Therefore, it is the opinion of this reviewer that the request is not medically necessary and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines

  DWC-Division of Workers Compensation Policies and

  Guidelines European Guidelines for Management of Chronic

  Low Back Pain
- ☐ Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)